

Skin cancer

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Basic rules

- The most important indication for excision of a naevus is suspicion of malignancy. Other indications include aesthetic considerations or the location of the naevus in an area exposed to friction. If naevi are excised for cosmetic reasons always estimate the eventual consequences of a scar and the tendency of the patient to develop keloids.
- A general practitioner can excise any naevus using local anaesthesia. Very large lesions and strong suspicion of melanoma should be referred to a specialist.

Naevi, melanoma

- The incidence of melanoma is increasing. Suspect a melanoma if a naevus starts to grow, change its colour, develop satellites, bleed, or discharge. A melanoma cannot be ruled out on clinical grounds, and it may develop on previously intact skin.
 1. "Ordinary-looking" naevus
 - The need for excision depends on the history given by the patient concerning changes, and aesthetic considerations or annoying location. Requests for the removal of solitary naevi should generally be granted even if the doctor considers the lesion benign.
 - The naevus is totally removed, but the margin of intact skin can be small.
 - The general practitioner often sees patients who require the removal of a large number of naevi either one by one or at the same consultation. Usually the patient can be reassured in conversation and by the removal of a few large naevi.
 2. "Slightly suspect" naevus

- For example, a naevus that looks benign but that has grown or changed colour (darker) or had bleeding or discharge according to the patient (Level of Evidence = C; Evidence Summary available on the EBM Web site).
 - Such a naevus should always be removed, and the excisional margin is determined by the appearance and location of the naevus.
3. Strong suspicion of a melanoma
- See Pictures 1, 2, 3 of the corresponding full text guideline available on the EBM Web site
 - Refer the patient to a plastic surgeon, surgeon, or a specialist in otorhinolaryngology or ophthalmology if a naevus has
 - markedly grown and changed its colour
 - become exceptionally large
 - developed satellites
 - appeared on the site of a melanoma that has been excised before.
 - Make sure that the patient attended the appointment and that the naevus was removed.

Treatment and follow-up of a melanoma

- In cases of melanoma the patient should be referred for further surgical treatment and the referring physician should make sure that the patient is treated without delay.
- A larger excision of the skin and subcutaneous tissue is performed around the tumour. The extent of the excision is determined by the location, thickness (Breslow classification) and depth of infiltration (Clark classification) of the tumour.
- Very superficial melanomas (Clark I - II, Breslow < 1 mm) should be excised with a 1 cm margin of intact tissue. Deeper melanomas should be removed with a 2 - 5 cm margin. The site of excision is reconstructed with a pedicle flap or free graft. Prophylactic evacuation of lymph nodes is performed in some cases of melanoma.

Follow-up of a melanoma

- Patients with a melanoma are followed-up every 3 months until 2 years have passed from the diagnosis. Thereafter, follow-up is continued every 6 months for 5 years. The unit responsible for follow-up (hospital or primary care) can be decided on locally. It is important that the same doctor always sees the patient.
- If the patient has numerous naevi or the syndrome of hereditary dysplastic naevi, follow-up of a melanoma should take place in a dermatological unit. High-quality photographs facilitate follow-up. These patients have life-time follow-up.
- At follow-up visits the general condition and symptoms are investigated, and the site of excision and local lymph nodes are palpated. Satellites of melanoma are usually felt as subcutaneous nodules and they are visible under the skin as dark spots.
- A melanoma first metastasizes into regional lymph nodes which should be followed-up carefully by palpation. If the clinical examination suggests the spread of a melanoma, a chest radiograph, blood count, liver function tests, and liver ultrasonography should be performed.
- If a melanoma has infiltrated the regional lymph nodes they are removed surgically. Cytostatics and interferon have been moderately effective in the treatment of metastasized melanoma.

Basiloma (carcinoma basocellulare, basal cell carcinoma,

BCC)

- See Pictures 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14 of the corresponding full text guideline available on the EBM Web site
- Basiloma or basal cell carcinoma is the most common malignant tumour in man. It is typically located in the face of an elderly person.
- A typical basiloma is a glittering tumour with elevated margins. Often ulceration develops in the centre. A so-called morpoid basiloma is difficult to recognize and its borders are difficult to determine.
- A superficial basiloma usually occurs on the trunk. Differentiation from psoriasis or eczema may sometimes be difficult.

Treatment and follow-up

- The general practitioner can excise (Level of Evidence = C; Evidence Summary available on the EBM Web site) a small, typical basiloma if he/she is familiar with the operative techniques in the area. Patients with a suspected basiloma on the eyelids or in the vicinity of the nostrils or ear canal should be referred to a specialist.
- The treatment of choice is surgery. The tumour is excised under local anaesthesia with a 5 mm margin of intact tissue, and reconstruction is performed if necessary by pedicle flap or free graft. A patient with basiloma should be followed-up for 5 years after surgery. Shorter follow-up may suffice for a solitary, small basiloma.
- A superficial basiloma, and some common basilomas, particularly in the elderly, can be treated with liquid nitrogen cryotherapy in a unit familiar with the technique.
- A basiloma metastasizes rarely. Because local spread is common special care should be taken in the treatment and follow-up of basilomas near the eyelids, nostrils, or ear canal.
- Small basilomas can be excised by the general practitioner who is also responsible for follow-up.
- Consider referring a young patient with basiloma to a dermatologist. Basiloma may be a manifestation of some rare inherited diseases.

Epidermoid carcinoma (c. epidermoides, c. spinocellulare, c. squamocellulare, spinalioma)

- Epidermoid carcinoma is rare compared with basiloma. It most commonly occurs on the face and hands. The usual form is an ulcerating prominence or scaling plaque.
- An epidermoid carcinoma should be treated by surgical excision with a margin of 1 - 2 cm, and by subsequent reconstruction. A developing epidermoid carcinoma on sun-exposed skin can be treated by liquid nitrogen cryocoagulation by an experienced specialist. Distinguish from solar, actinic or senile keratosis (See related EBM Guideline: **Solar keratosis** available on the EBM Web site).
- Bowen's disease is a superficial, "incipient" (in situ) carcinoma. It can be removed either surgically or by liquid nitrogen cryotherapy. The operation is usually performed by a surgeon, plastic surgeon, otologist, ophthalmologist, or dermatologist specialized in cryotherapy.
- A patient with epidermoid carcinoma should be followed-up at 6-month intervals for at least 5 years after treatment.

Lip carcinoma

- Lip carcinoma (epidermoid carcinoma of the lip) is usually situated in the lower lip (Picture 15) (See Picture 15 of the Corresponding full text guideline available on the EBM Web site). It presents first as an erosion or ulceration that can be preceded by leukoplakia.
- A lip carcinoma is treated surgically by excising the lip at the site of the tumour, with a margin and by performing reconstruction.
- A lip carcinoma easily metastasizes in the lymph nodes under the skin, which should be palpated at follow-up examinations.

Prevention of skin cancer

- There is little evidence of interventions to prevent skin cancer. Sunscreens may be effective in the prevention of solar keratoses (Level of Evidence = C; Evidence Summary available on the EBM Web site)

Related evidence

- Dermatoscopy may have a potential to improve the diagnostics of malignant melanoma, but this has to be verified with higher quality studies in primary care (Level of Evidence = D; Evidence Summary available on the EBM Web site).

Bibliography

1. Whited JD, Grichnik JM. Differential diagnosis of mole and melanoma. JAMA 1998;279:696-701
2. The Database of Abstracts of Reviews of Effectiveness (University of York), Database no.: DARE-988293. In: The Cochrane Library, Issue 4, 1999. Oxford: Update Software
3. TThissen MR, Neumann MH, Schouten LJ. A systematic review of treatment modalities for primary basal cell carcinomas. Archives of Dermatology 1999;135:1177-1183
4. The Database of Abstracts of Reviews of Effectiveness (University of York), Database no.: DARE-992074. In: The Cochrane Library, Issue 1, 2001. Oxford: Update Software
5. Prevention of skin cancer: a review of available strategies. University of Bristol Health Care Evaluation Unit 1995;31
6. The Database of Abstracts of Reviews of Effectiveness (University of York), Database no.: DARE-950349. In: The Cochrane Library, Issue 4, 1999. Oxford: Update Software
7. Mayer J. Systematic review of the diagnostic accuracy of dermatoscopy in detecting malignant melanoma. Med J Aust 1997;167:206-210
8. The Database of Abstracts of Reviews of Effectiveness (University of York), Database no.: DARE-978307. In: The Cochrane Library, Issue 4, 1999. Oxford: Update Software

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